Provider Advisory Group
April 26, 2016
6:30 – 8:00pm
Meeting Minutes

Attendees: Elizabeth Roberts, Charlotte Moriarty, Claire Nadeau, Megan Ramney, Dieter Pohl, David Kroessler, Steve Brown, Sarah Fessler, Sam Nessy, Adam Johnson, Donald Murphy, Newell Ward, Alan Post, Gary Bubly, Alicia Klein, Peter Hollman, Matthew Smith, Mike Migliori, Brett Aaron, Sam Marullo, Lauren Lapolla

I. Welcome – Secretary Roberts

II. Alternative Pain Management Treatments & Pain Treatment Referrals
Given that Director Alexander-Scott has been held up at a hearing at the state house, I will ask Providers to get started here with their conversation. Dr. Gary Bubly, emergency department Lifespan, talk a bit about your world.

Gary Bubly: Across our sites see about 250,000 visits annually. Emergency room visits nationally accounts for 5% of opiate prescriptions written, many for short-term things. Voluntarily, internally, we created a prescription limit as a form of guidelines on opiods. The policy is now on the Department of Health (DOH) website, and in that we recommended limiting prescriptions to a three day supply with limits on resupply. Many emergency department visitors are there for pain management, so need to take care. In addition we have done a number of things to address the opiod epidemic in the state, we are some of the first to start dispensing Naloxone in the departments; also started working with Anchor recovery coaches, and RI Hospital (RIH) emergency department is the single largest consultant of Anchor recovery emergency department by a significant margin. We have also done stuff within the emergency department – play a Naloxone video as a form of education. We try to encourage patients to seek treatment for opiod overdose and addiction.

Matthew Smith: When a patient comes in with chronic pain what resources are available in terms of behavioral health services?
Gary Bubly: At RIH there is active inpatient as well as adult liaison. At Miriam we do not have in-patient psych but do try to connect with outpatient services. Lifespan is working to develop centers for opiate addition, treatment within the system, but that has been a slow process.

Megan Ramney: For those with chronic pain, not coming in for an overdose, where they clearly meet definitions of abuse on chronic pain, it relies on communication between the patient and the provider. We do

have studies going on, but there is a systemic lack of general services, and we try to use our online resources.
David Kroessler: Do you feel you have enough referral sources for buprenorphine?
Megan Ramney: No. Not at all – I spent an hour and a half trying to get that for a patient this week, and couldn't do it.
Secretary Roberts: We can have Director Alexander-Scott speak further to that when she gets here, as there has been an increase in waivers and training.

Gary Bubly: I have the waiver and did the training, but as we all know one saboxone dose is not going to solve the problem.
Dieter Pohl: Is there a registry somewhere of all the pain clinics or saboxone prescribers somewhere? We kneed someone who does the whole thing?
Secretary Roberts: Let's refer that question to Director Alexander-Scott for sure.
Gary Bubly: You can get listed in some of these national referral centers, but there is no easy reference for us in our emergency department. We do not have a listing. Plus there is also the 24/7 nature of our business and the way these patients present, but the system doesn't have a way to meet that just yet.
Secretary Roberts: Medicaid is putting a sizeable chunk of money into the budget along with the Department of Corrections to support that growth.
Gary Bubly: The other issue is the co-pay situation, and all that type jazz that doesn't meet the 24/7 world.

Secretary Roberts: Welcome to Director Alexander-Scott who has just joined us after leaving the General Assembly hearings. Can you jump in here?
Director Alexander-Scott: We have access to who those are, haven't made them public yet, but is a listing of resources that are available for outpatient treatment, and it is worth considering a model that with agreement of sab providers emergency department will know what to refer. The model is the Centers of Excellence, so that emergency departments can refer to that home and facility. That would be the place where people can be started and stabilized on sab, and once they are then refer them out to the primary care provider.
David Kroessler: We as buprenorphine providers are limited to a number of patients. But for other prescription I can write for thousands of patients. There is a disconnect…
Director Alexander-Scott: We actually last month just had our federal partners allow us to expand that number up to 200.
Dieter Pohl: Not just the emergency room, when we all have these patients who take analgesics and they still have pain a few months later, who do we send them too.

Director Alexander-Scott: The goal will be our centers of excellence. Ideally these centers would have wrap around support options – not only behavioral health components but also peer recovery coaches.
Dieter Pohl: Not just saboxone, but also pain management. Chronic oxycontin, chronic abuse – I don't want to give them oxycontin forever. If there is something else going on how do we deal with this? I see that in practice very frequently. In the past only pain specialists that would prescribe chronic opiods, but they are very few. I think that knowledge is what I would need.

III. **Pain Management & the Governor's Overdose Prevention & Intervention Task Force**

Director Alexander-Scott: Good segue to move through this PowerPoint very quickly. [Slides available upon request via email to lauren.lapolla@ohhs.ri.gov]. Let's also hear from you all to think about models that can be touted for where to go.

Steve DeToy: Last week the SAMSA grant that RIMS, DOH & BHDDH have signed to work on getting a workplace map showing places for pain medicine specialists and other relevant providers to really augment what you have been talking about there, with deliverables in the next few months.
Sarah Fessler: This is a fantastic plan, director, truly. I hope it moves forward in as smooth a way as possible. We are trying to take care of people there, recognizing that having a center for excellence to refer people back to will help with getting other providers to sign up for the buprenorphine training. Can you talk a bit about access though?
Director Alexander-Scott: Absolutely it is a work in progress.

Donald Murphy: At CareNE we are working on an integrated spine care pathway. It is all about the prevention part of this – up front efficiencies, so that what happens up front influences what happens at the back end. If you mange the situation well up front there is no conversation on opiod addiction as never got started on anything. Their pain was managed, often self managed by non-pharmacological methods.
Director Alexander-Scott: That is perfect that is the exact model we are trying to replicate. We want to scale that model everywhere we have the capacity to do it, and at the state level help bring attention to the fact that this support system is here, for chronic pain particularly for musculoskeletal patients.
Donald Murphy: Yes will be primary care spinal referrals to avoid surgeries, be self-sufficient, and then identifying those who do need higher levels of pain management, injections, surgeries, making sure they get the help they need. It is an organized pathway.
Director Alexander-Scott: I would love to meet with you further along

with others.

Claire Nadeau: Where will this center for excellence be?
Director Alexander-Scott: Ideally we would love 5 – between 3-5 statewide. Build it out of our existing pain treatment clinics exist, our methadone clinics. Expand their abilities to administer and get people organized. Also looking to get Eleanor Slater Hospital organized as well.
Secretary Roberts: We are funding largely through Medicaid and July 1 start paying for those services.

David Kroessler: As a director of a buprenorphine clinic, we teach our med students how the patients get addicted. We have identified three types of users – iatrogenic, those self-medicating, and recreational users. Usually the iatrogenic users are the most common - some patients say after one pill they feel normal, they feel alive and they are addicted from that first pill. How do we avoid that?
Donald Murphy: By not giving the pill in the first place.

Secretary Roberts: Anecdotal – one of my close colleagues had a husband who had surgery recently, and tired to not take a prescription for pain management with them and wasn't allowed to leave without it.
Dieter Pohl: As a surgeon I have to say, there are some patients who say they have a high pain threshold, and they go home and then three hours later they call us, at which point it's too late to prescribe vicontin.

Director Alexander-Scott: In addition to partnering with Massachusetts, we also want to work towards mandating data waiver training for med students, so that residents coming up know how to engage. We hear so often that primary care providers, between the challenges of this population and the regulatory hurdles, they often are cautious against getting this training – we want to start the training early to avoid that fear led caution, and get primary care providers comfortable with this work. We are also thinking through ways that are helpful for the providers, and help to give parameters to providers for limiting how much opiod is prescribed for acute pain management prescription. The slide suggests limiting prescriptions for acute pain to an immediate release opioid with total daily dose is 25 MME/day or less with a limit of 20 total doses or less. Usage on dosage amount, so there is an option for prior authorization if need to go beyond, but allow for prescribers to see what they can do.
Dieter Pohl: I think this is very good. I do not know if there is a law now, but I tell my patients I cannot give them more after two weeks. And they accept that.

Mike Migliori: There is a bill on the senate side to limit the initial prescription to five days with very few exceptions (except hospice care or

cancer patients). One of the things that we would like to make sure is that we have access to the things we do need, but I agree patients don't need 50 vicontin for a sprained ankle. I can prescribe electronically through Lifespan, but cannot on the weekend. So making sure patients have access to things they do need – and immediate post-op care is going to need monitoring. First day after surgery you need those meds, but can limit. Watching the pendulum go both ways, I want to be sure we do not over swing and we are back at this table wondering why we cannot manage pain.
Director Alexander-Scott: Does the prior authorization help that? If you need to go beyond the initial small dosage as suggested here?
Mike Migliori: Perhaps yes. I do not think there will be many situations where you would need to go beyond five days; I am just curious, do you know why… what was it that reduced the number of iatrogenic prescription deaths?
Director Alexander-Scott: I think it has been these conversations, the discussions about over prescribing conversations; really been the last two or three years, showing there has been effectiveness with awareness. Changing the conversations and engaging the providers helps us to do that.

Claire Nadeau: On the receiving end of specialty care, I have received some patients who have not … who still have significant pain issues, and are coming to me saying the specialty discharged me, but I still have acute pain. The strategies of trying to manage these patients is tough; the reality is it has to be a partnership. There will be patients who take the one pill and are addicted, those are hard to predict.
David Kroessler: This concept of long term opioid use causing hyperalgesia is under recognized.

[Anesthesiologist *name forthcoming*]: So I think the first thing I would like to say is this practice of legislating health care from the state house is a bad idea. They do not have the expertise – I feel it should be redirected to the regulatory side, not the legislating. This huge variability even within certain patient populations – you cannot group those with total shoulder surgeries and those with rolled ankles. If you bring patients back every week I am concerned would overload surgeons and not have time to se those who need it. It is interesting to me – there needs to be more research. An article on anesthesiology in 2014 that looked at pathways to the knee. While the block of pain lasted only 24 hours, the relief lasted far longer. There needs to be more research there; using pre-op blockade of pain decreases the pain after surgery. Also changes how we do the anesthesia in surgery based on that info. In the iatrogenic group, we do not know which patients are at greatest risk, but I think working at preventing pain in the first place may be key to preventing extra efforts down the road. Other thing not brought up are co-morbidities. Patients

with sleep apnea, for example are a different animal to those with opiod treatments.

Matthew Smith: Thank you for getting everyone together – A quick clarification. The funding for Centers for Excellence will come from Medicaid but will those with commercial insurance be able to go through?
Director Alexander-Scott: We are looking for strong support from Medicaid, but we are looking for partnership from private insurance. They can go.

Matthew Smith: You mentioned these other places that offered these other good programs like massage and acupuncture etc. – I am interested in how they are implemented into their practice models? You had AMI in the state who had behavioral health nurse care managers and the payment model to incorporate these alternative treatments. There isn't an existing business model for that in the private sector. CareNE and Lifespan aren't funding that at this time – challenging. Do you envision any state support or promotion of a payment model to help support or encourage incorporation?
Director Alexander-Scott: We want to start somewhere. The folks I have spoken to have the backing similar to the CareNE example made earlier. That is on one end of the spectrum, have everything co-located. The other end of the spectrum is at the least, in large primary care provider practices, establish a linkage with partners in the community, to expedite referrals in those area. We want to explore, develop and grow, and look for opportunities for payment, reimbursement etc. Seeing benefit in a structure format raises the attention towards support for formal payment structures.

Matthew Smith: Thank you. I think everyone wants to see less deaths, while there is a lot of red on balance sheets, at times I fear for some organizations that have to show a positive bottom line that is a challenge. You brought up other models, like Vermont. Vermont is doing wonderful things, particularly with things like Healthy People 2020. I think the important part of understanding chronic pain is that it is chronic. We have to promote wellness as part of that. Is there any opportunity to link us with Healthy People2020, particularly nutrition and exercise, particularly with Anya Rader Wallack now with the state?
Director Alexander-Scott: Director Wallack is certainly an awesome resource here. That actually segues to something I love to talk about which are our population health goals. Our DOH website shows our model for these population health goals. There are goals, there are strategies. The purpose of the goals is to have them align with the national Healthy People 2020 goals, but have those goals be RI specific. One goal then is reducing substance abuse in our state. That focus on wellness is really the driver, even as we are developing our states

population health behavioral health plan, while there is a disease focus, we are looking to transition that overtime to a wellness focus, and to expand that def to include health care. Health care is 10% what determines our outcomes, but the other 90% are a myriad of social, economic, behavioral health, and a small amount of genetics. We do want to partner with other states, other state partners to align, to measure.

Secretary Roberts: Director Wallack was very involved in Vermont reforms, and is now our Medicaid director. More and more we look at what we pay for and how we connect with health outcomes. Also through my office looking more at all payer approaches. Like with the centers for excellence, it is not just Medicaid approaches – working on types of practice and payment models across the whole system, rather than just doing that in our Medicaid world. Director Wallack's experience in VT, combined with our SIM grant will be very valuable moving forward.

Alicia Klein: As one of the only pediatric providers in the room, I want to say that as you build the centers for excellence, think about the needs of adolescents. The state has a complete lack of resources for people with substance abuse issues under 18. The needs of that demographic need to be considered. Fortunately right now the demo of overdose deaths in RI is largely the mid 40s, yet as heroin gets cheaper, as prescription drugs trickle down, we need to be able to treat that age group.
Secretary Roberts: We have a group in state gov't called the Children's Cabinet which does work together to bring issues just like that to the forefront of our policy discussions.

David Kroessler: Using the PMP, is there any thought to looking at the heavy prescribers at these products?
Director Alexander-Scott: Yes we are looking at the data on this, and using that data to reach out and help explain the dangers of what happened.

Alan Post: I think this is an important issue. RI has taken steps to address this issue, going back to funding in 2011, and alternative therapies pilot that concluded in 2015, and the data is being evaluated. I think there will be move for this model expanding further to work the front end eventually in the future, and give an alternative to some of the prescription complications further. (That was the AMI model, and it is still continuing through United in the Medicare world) It was based on the community of care population, represented high cost high use, they were over 2,222 per year with high number of emergency department visits – as was said to me, if we can deliver on this population, it could be done with an easier population. There are very committed holistic trained nurses. For primary care providers it is a huge help for this population. United sent a newsletter out to their Medicaid population and it

described someone who had multiple health issues, addicted to opiods, got on the program, got off meds through an acupuncture delivery model, got his life back, and it is a helpful area. The voices are being heard, there are case stories and hard data. I think our state can lead the nation, as I believe one of the few three year models exploring alt pain therapies. It is a complicated issue and hopefully within the next few months we will have a full review available.

Steve Brown: I can talk a little bit about dentistry. It is a forgotten subject at time, but many patients show up at emergency departments with dentistry issues that cannot get treatment. Teeth get no love in this state as our reimbursement rates are very low. The capacities in the health centers are such that we cannot keep up with the Medicaid population needs. Unfortunately, often these patients become addicted to opiods as they are always having pain. Many are scared to go to the dentist – a lot of patients fear is an issue too. We are trying to get them out of the emergency rooms and into dentist chair. There are few true dental emergencies. I take out many wisdom teeth on a lot of adolescents, and we see that is a problem as that is often where teens get a first taste of an opiod. It is something we are trying to take a look at. In my opinion, it is something that we need to work with the group and a lot of times we are forgotten, but we do try to get involved. No one out there is prescribing the 30 day dose of opiod in my world, but unfortunately to your point, one pill can at times be the issue. The ADA and the AOS are trying to work on this, get better treatment options, and work on pain management practices that are better than opiod use. The big thing is treatment, and in this state sadly we do not get the love.
Secretary Roberts: Anyone else have anything they would like to share on best practices?

Dieter Pohl: The dosage explained here – what does that relate to?
Peter Hollman: It is a mathematical equivalent with morphine.
Alicia Klein: I am glad you bought that up, as a pediatrician we rarely do prescribe them, but we would need a cheat sheet and explanation to be sure we do this right.
Peter Hollman: The Prescription Monitoring Program (PMP) does bring that for you.
Dieter Pohl: I agree, but if it takes me ten minutes in my office to see what a patient is all taking, then they show up, that can be a challenge. We can make it easier somehow at least on these limits. Who authorizes the further needs?
Sam Marullo: The payers.
Dieter Pohl: Okay, often that system can take days. Should look at that now, for if a patient is in pain we may need the extender in place soon so that in an hour we can get the pre-auth.
Sam Marullo: The one Director Alexander-Scott was talking about is

designed to nudge docs in the right direction, but after the five days you can write as needed.
Mike Migliori: The other bill is five days and nothing about pre-auth to extend beyond that.
Dieter Pohl: I can write a second one without problem then. Okay.

IV. Public Comment

V. Adjourn